January 31, 2003

The Honorable Richard B. Cheney
President of the Senate
U.S. Capitol
Washington, DC 20501

Dear Mr. President:

The Balanced Budget Refinement Act of 1999 (BBRA) directed the Secretary of the Department of Health and Human Services to develop a per diem prospective payment system (PPS) for inpatient psychiatric facility care and submit a report to the Congress describing the PPS. The Centers for Medicare & Medicaid Services (CMS) of course will develop and implement the PPS. The BBRA Conference Report charged the Medicare Payment Advisory Commission (MedPAC) with reviewing the report and assessing the payment system's potential effects on rural psychiatric providers.

Because the publication of the proposed rule for the PPS is expected in March 2003, we are submitting our preliminary comments now. These comments are based on one approach that CMS reviewed in its report—a regression model developed by The Health Economics and Outcomes Research Institute in collaboration with the American Psychiatric Association. We will formally comment on CMS's proposal once the regulation is published.

In its August 2002 report to the Congress, CMS discussed a payment system based on a regression model that relates per diem resource use for beneficiaries treated in psychiatric facilities to patient and facility characteristics available from CMS's administrative data. Examples of patient-specific characteristics are principal diagnoses, secondary diagnoses, or age 65 years or older. Examples of facility-specific variables are location in a rural area or the extent of teaching activity. The regression model explains 20 percent of the variation in per diem resource use (charges adjusted by cost-to-charge ratios to derive costs) among beneficiaries treated in inpatient psychiatric facilities.

We conducted a payment impact analysis of the model described in CMS's report. For purposes of our analysis, we included government-owned hospitals in the model. The analysis shows that the impact on rural facilities would be favorable—payments to rural facilities would be 3.3 percent higher than payments under the current system. The most noteworthy impact would be the increase in payments to government-owned freestanding hospitals—payments under the new system would be 18 percent higher than under the existing system.

Our analysis of the regression model described in the report and its potential impact raises major issues that CMS should consider in developing and implementing the PPS. The issues fall into three broad categories:

- determination of appropriate payments for patients treated in different types of facilities,
- implementation and administration issues, and
- system design and statistical methods.

Determination of appropriate payments for patients treated in different types of facilities

The two most important issues have to do with determining payments for different types of facilities. We believe that CMS will need to do additional work to determine appropriate payments for inpatient psychiatric care.

The Secretary should examine more fully the differences between hospital-based and freestanding psychiatric facilities. CMS found a difference in costs between hospital-based and freestanding psychiatric facilities, and states that the greater cost of hospital-based units reflects the increased complexity of patients admitted from the acute care hospital with still-unresolved medical problems. However, MedPAC found that only 21 percent of patients treated in hospital-based psychiatric units had an acute care hospital stay in the month before their psychiatric admission. Thus, it is unclear if patient complexity accounts for this difference.

The regression model shows that hospital-based units have 18 percent higher costs than freestanding psychiatric hospitals (nongovernment). The regression payment model would, without adjustment, result in hospital-based facilities receiving a $123 higher payment per day compared with freestanding facilities. Traditionally, CMS has not distinguished between hospital-based units and freestanding facilities under prospective payment. In addition, research on acute care hospitals' cost allocations has indicated that hospitals have over-allocated overhead costs to units paid under cost-based reimbursement—15 percent of the units' costs resulted from this over-allocation.[1] Thus part of the difference in costs between hospital-based and freestanding psychiatric facilities may also reflect cost allocation issues.

Therefore, CMS should examine more fully the differences between hospital-based and freestanding facilities—e.g., how much of the difference in costs is related to allocation issues or to differences in patient complexity, and whether the payment system adjusts sufficiently for that complexity. Ideally the payment will "follow the patient," and the facility will be properly reimbursed regardless of whether it is hospital based or freestanding.

---

[1]Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. March 2001.

The Secretary should conduct more research on government-owned psychiatric hospitals' costs to determine how much they should be paid under the PPS. MedPAC prefers that government-owned hospitals be included in the PPS. Doing so, however, will result in government hospitals receiving payments 7-18 percent greater than under the current system. More work is needed to determine whether this is an appropriate outcome for government-owned hospitals, especially because the PPS will be budget neutral and this means the additional money paid to government hospitals would come from other non-government owned facilities.

Government-owned hospitals treat only 6 percent of Medicare beneficiaries who are treated in psychiatric facilities, but these hospitals function as a safety net, admitting patients whom other facilities will not accept. Government hospitals have lower costs per day than other psychiatric facilities, although it is not known why they are lower. Payments should not greatly exceed costs of furnishing care. CMS will need to explore further the differences between patients treated in government-owned versus other types of facilities, and examine the relationship between those differences and the cost of their care to determine appropriate payment amounts.

Implementation and administration issues

The next two major issues relate to implementing and maintaining the PPS.

Ideally, the transition from the current system to the PPS should be gradual, but the Secretary should have the authority to allow facilities the option of moving to 100 percent PPS rates before the transition is complete; the transition to the payment system should be budget neutral. Beneficiaries who need inpatient psychiatric care are an extremely vulnerable group. In addition, the psychiatric provider infrastructure is thought by some individuals to be vulnerable.[2] How the transition from the current payment system to the PPS is structured may determine whether the infrastructure becomes stronger or weaker.

A more gradual transition would allow psychiatric facilities that have had generous payments under the current system more time to adjust to the lower PPS rates. An option for facilities to receive 100 percent PPS payment before the transition is complete would allow facilities who have received lower payments under the current system to benefit from PPS immediately. Ideally, having a slow transition to PPS, coupled with an option for some facilities to move to full PPS payments immediately, protects the provider infrastructure. CMS would need to estimate the number of facilities likely to take the option because the base rate would still need to be budget neutral. When considering the length of the transition and the effect of a 100 percent option, CMS will need to assure that no group of facilities is overly penalized by the choices made.

---

[2]Eselius L. Prospective payment for inpatient psychiatric services: a review of the evidence and key issues. Unpublished paper. Written 2000.

The Congress should make clear where the authority to annually update payments rests. Current law is silent on updating payments to psychiatric facilities. The Congress should make clear whether the authority to update payments annually will be specified in law or rest with the Secretary. Additionally, we believe that the Secretary should have the authority to adjust the annual update to payments for case-mix creep as needed. Providing the Secretary with this authority will ensure the most efficient administration of the new PPS.

System design and statistical methods

Finally, the last category of issues includes system design and statistical methods.

The Secretary should decrease per diem payments continuously. The payment model would use a system called "declining block pricing," with per diem payment rates for blocks of days declining as stays get longer.

These rate blocks create financial incentives for providers to keep patients at length-of-stay intervals just under those for rate reductions. A smoother decline in rates would better approximate the incremental costs of an additional day, and prevent incentives for providers to discharge patients before rate reductions are scheduled to take place. Therefore, we believe that the per diem payments should decrease continuously.

The Secretary should explore alternative models of per diem costs. In analyzing the relationships between providers' unit costs and potential payment variables, CMS has commonly transformed costs into logarithmic values instead of using raw (untransformed) values. Using the regression results to calculate payment rates requires retransforming the logged values to dollars. New empirical evidence demonstrates that models using large samples of raw values produce more reliable estimates than models using log transformed values, although the standard errors must be corrected for inference purposes.[3] The database used to construct the regression payment model contains about 400,000 observations, a large sample. Therefore, CMS should explore logged and unlogged cost variables.

When the proposed rule is published, MedPAC will formally comment on it. Once the PPS is implemented we will monitor it as part of our regular workload.

---

[3]Manning WG, Mullahy J. Estimating log models: to transform or not to transform? Journal of Health Economics. July 2001, Vol. 20, No. 4, p. 461–494; Deb P, Burgess JF. A quasi-experimental comparison of econometric models for individual health care expenditures. Unpublished paper. Written 2002.

Please do not hesitate to call Mark E. Miller, Ph.D., Executive Director, or Sally Kaplan, Ph.D., Research Director, at (202) 220-3700 if you have questions about this letter or about MedPAC's ongoing work.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Identical letter sent to the Honorable J. Dennis Hastert

cc: Honorable Charles E. Grassley, Chairman, Senate Committee on Finance
Honorable Max Baucus, Ranking Member

Honorable William M. Thomas, Chairman, House Committee on Ways and Means
Honorable Charles B. Rangel, Ranking Member

Honorable Nancy L. Johnson, Chairman, Subcommittee on Health, House Committee on Ways and Means
Honorable Pete Stark, Ranking Member

Honorable W.J. "Billy" Tauzin, Chairman, House Committee on Energy and Commerce

Honorable John D. Dingell, Ranking Member

Honorable Michael Bilirakis, Chairman, Subcommittee on Health, House Committee on Energy and Commerce
Honorable Sherrod Brown, Ranking Member

Honorable Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services
Honorable Thomas A. Scully, Administrator, Centers for Medicare and Medicaid Services

Enclosure: Balanced Budget Refinement Act of 1999 Conference Report

Balanced Budget Refinement Act of 1999 Conference Report

SEC. 124. PER DIEM PROSPECTIVE PAYMENT SYSTEM (PPS) FOR PSYCHIATRIC HOSPITALS

Current law
No provision
.
H.R. 3075, as passed
Requires the Secretary to report to the appropriate Congressional committees by October 1, 2001 on a per diem-based PPS with an adequate patient classification system for psychiatric hospitals and distinct-part units which would be implemented in a budget-neutral fashion for cost reporting periods beginning on or after October 1, 2002. The Secretary may require such psychiatric hospitals and units to submit information to develop the system.

S. 1788, as reported
Requires the Secretary to report to Congress within 2 years of enactment on a PPS for psychiatric hospitals and units. The study should take into account the unique circumstances of psychiatric hospitals in rural areas.

Agreement
The agreement includes the House provision. The parties to the agreement are aware that changes to payments for psychiatric units and hospitals contained in this bill could affect the provision of mental health services in rural areas. Accordingly, the parties to the agreement request that MedPAC evaluate the impact of these changes and make recommendations if further modifications are needed to maintain the availability of rural hospitals to provide critical behavioral health services.